



American Optometric Association

**2005 WHITE HOUSE CONFERENCE ON AGING SOLUTIONS FORUM
"EYE CARE ACCESS: ELIMINATING BARRIERS FOR SENIORS AND
BABY BOOMERS"**

Post Event Summary Report

Date of Event: June 24, 2005

Location of Event: Enterprise I, Hyatt DFW Hotel, Dallas, Fort Worth/Texas

Number of persons attending: 56

Sponsor: American Optometric Association

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Attending this Solutions Forum were White House Conference on Aging representatives Dorcas R. Hardy, Chairman of the 2005 White House Conference on Aging (WHCoA) Policy Committee, and Rodolfo (Rudy) Arredondo, Ed.D. Dr. Arredondo, of Texas Tech University Health Sciences Center.

The 10 panelists from around the country who participated in the forum presented more than 30 "solutions" to diminish or eliminate barriers to eye care that many older Americans face. Eight of the panelists were optometrists. One optometrist panel member represented the National Vision Program at the U.S. Centers for Disease Control and Prevention. Another optometrist offered perspective as a provider who works at a Veterans Administration health care facility. A non-optometrist panelist represented the National Eye Institute of the U.S. National Institutes of Health.

The panelists presented barriers and solutions in four of the six topical areas outlined in the WHCoA Draft Annotated Agenda. Solutions ranged from urging the full utilization of optometrists in the National Health Service Corps student loan repayment program administered by US Department of Health and human Services, to increasing disease prevention education programs

for senior citizens, to increasing gerontology courses for students at schools and colleges of optometry.

What follows are the top three solutions offered in order of priority. Those are followed by a bulleted listing of all the identified barriers and solutions presented. Under separate attachments are the opening remarks given by AOA's out-going President Wesley Pittman, David Crist, O.D. Chair, AOA Advocacy Group and Michelle Haranin, O.D., Chair, AOA Federal Relations Committee. These are followed by the individual panel presentations. Finally, additional solutions in the area of long-term care were submitted after the conclusion of the forum

Top Three Eye Care Solutions

Priority #1: Federal health policy makers must allow the full participation of optometric students in the National Health Service Corps Student Loan forgiveness program administered by the Health Resources and Services Administration within the U.S. Department of Health and Human Services. This would serve as a powerful incentive to young optometrists who desire to serve older people in medically underserved areas at the highest level of eye care they are state-licensed to provide, but who, because of student loan obligations, must seek higher-paying positions elsewhere.

Priority #2: Federal, state, and local public health officials must support and advocate for the full participation of optometrists in federally-qualified, community health centers in underserved rural and urban areas to increase access to eye care for older Americans, whose risk for vision problems and eye disease increases with age.

Priority #3: Schools and colleges of optometry, along with medical schools and other health professional institutions of higher learning, must be encouraged to introduce or improve upon basic course work in gerontology, create geriatric departments, and recruit faculty trained in gerontology.

All Eye Care Barriers and Solutions Presented

HEALTH AND LONG-TERM LIVING

Barriers:

1. Lack of coordination and Integration of eye health services
2. Need for new and more integrated data to enhance and monitor performance-based vision programs
3. Not recognizing the need for care as readily as others. And even with increased awareness, some people may not act as quickly upon those needs.
4. The number of people who are visually impaired or blind as a result of acute macular degeneration, diabetes, and glaucoma is growing rapidly, and the direct and indirect costs associated with vision loss are very high. But access to care is often limited or delayed. High-risk patients may receive no care, while low-risk patients may receive more care than needed.

Solutions:

1. **Priority #1:** Federal health policy makers must allow the full participation of optometric students in the National Health Service Corps Student Loan forgiveness program administered by the Health Resources and Services Administration within the U.S. Department of Health and Human Services. This would serve as a powerful incentive to young optometrists who desire to serve older people in medically underserved areas at the highest level of eye care they are state-licensed to provide, but who, because of student loan obligations, must seek higher-paying positions elsewhere.
2. Improve the effectiveness of vision screening through adoption of evidence based techniques, standardized recording and referral guidelines.
3. Improve communication and coordination between eye care providers (ECP's) as well as between ECP's and other health care providers. Utilize electronic medical records to identify patients at risk for developing diabetic retinopathy and other eye diseases.
4. Define those risk groups and urge annual examinations as well as increasing the overall number of patients receiving comprehensive eye examinations.

5. Develop more programs to support the full range of services required by people with vision impairment. Create mechanisms that would more rapidly translate the proven results of research and technology into community practice.
6. Implement national eye care and aging education initiatives aimed at older adults and their caregivers, as well as at health care professionals, especially primary care physicians.

OUR COMMUNITY

Barriers:

1. Inadequate access to health care in some rural and urban settings. Many older individuals must travel vast distances from home to health care providers and facilities. This adversely impacts the timely delivery of care.
2. Socioeconomic disparities: In underserved poor urban areas, the barrier to health care is not only a matter of distance but also a matter of socioeconomic disparities and cultural isolation that can lead to increased incidence of disease in “at risk” aging populations.

Solutions:

1. **Priority #1:** Federal, state, and local public health officials must support and advocate for the full participation of optometrists in federally-qualified, community health centers in underserved rural and urban areas to increase access to eye care for older Americans, whose risk for vision problems and eye disease increases with age.
2. Federal and state officials should support tax benefits or loan forgiveness opportunities for eye care professionals who practice in rural communities which are in Health Professions Shortage Areas (HPSA's) or Medically Underserved Areas (MUA's).
3. Public health officials at all public government should support the initial training and continuing updating of skills for eye care professionals who serve in underserved rural and urban areas. Funding partnerships and opportunities with state governments should be explored to encourage states to train health professional students for these communities and involve them in service learning with the elderly while they train.
4. Create and offer provider incentives for overlapping clinical training between family practice physicians and optometrists. There is much that a family practice physician could learn about eye signs of systemic disease within an eye clinic, and there is much that optometrists could learn about systemic disease from rotations within family practice clinics – all of which could be directly applicable to an at-risk aging, rural, and urban populations.
5. Create and maintain more community “eye care” centers in underserved rural and urban areas. For educational and governmental institutions, opening clinics in underserved areas can go a long way toward accomplishing this goal.
6. Allow private practitioners who provide services within underserved urban areas to participate in “Pay-for-Performance” reimbursement rates, an idea that’s being discussed in Congress and at the Centers for Medicare and Medicaid Services.
7. Increase access to eye-care for all older Americans for the diagnosis and treatment of eye diseases -- the risk of which increases with age. Towards that end, for example, it's crucial that Congress re-evaluate Medicare's Sustainable Growth Rate (SGR)

physician payment formula to develop a fairer physician payment formula that ensures reliability, consistency and fairness in determining annual fee updates. Not correcting this problem jeopardizes the provision of eye care and other Medicare services to older Americans.

8. Educate citizens about the four most common causes of vision loss. The Ohio Optometric Association has developed the Adult Vision Simulator Card that can be used to aid in educational programs in communities. By demonstrating to those with normal vision the effects of cataracts, glaucoma, macular degeneration, and diabetic retinopathy, we can better educate the public about the importance of a lifetime of comprehensive eye care. Since all of these problems increase with age, it is especially important that we educate the elderly within our communities. Also, since both glaucoma and diabetes are more common in African Americans, it is vital that we educate them about these very important diseases.
9. Create incentives for states to develop creative programs that encourage elderly persons to get comprehensive eye examinations, as optimum vision is important in mobility, driving and maintaining independence. This will benefit communities by reducing preventable vision loss from age-related macular degeneration, cataracts, diabetic retinopathy, and glaucoma. It will also make our roads safer, and even decrease the number of broken hips from falls. (The State of Ohio is considering a program where any older driver who gets a comprehensive eye exam can get a discount on his or her auto insurance.)
10. Provide increased funding for transportation programs that serve the rural elderly. By being willing to provide transportation for patients, or by taking eye care to patients, we can ensure that the visual needs of all older Americans are met.
11. Remove attitudinal barriers at the service delivery level. Barriers are not only physical, but also cultural or attitudinal in nature. Something as seemingly benign as a negative tone of voice on the phone may become a barrier to a patient seeking care. By being sensitive to patients of all cultural and socio-economic backgrounds, barriers to access can be reduced.

THE WORKPLACE OF THE FUTURE

Barriers:

1. Ageism: a major barrier facing older workers who want to extend their productive work careers. Ageism is the prevailing fears, distrusts, and prejudices directed toward them. The word, coined by Dr. Robert Butler, aging expert and psychiatrist, captures an attitude that discriminates, separates, and stigmatizes older adults on the basis of chronological age. Ageism fosters myths and stereotypes about older workers that are not true.
2. Inflexibility: Many employers consider it too difficult to maintain an accessible, safe, conducive work environment while accommodating the needs of older workers or making the necessary modifications in the workplace for them.

Solutions:

1. **Priority #1:** : Schools and colleges of optometry, along with medical schools and other health professional institutions of higher learning, must be encouraged to introduce or improve upon basic course work in gerontology, create geriatric departments, and recruit faculty trained in gerontology.

2. Employers must educate themselves about ageism. Studies consistently find that older workers are more reliable, often showing greater company loyalty than their younger counterparts and reporting fewer absentee days.
3. Increase professional experience in caring for older patients through increased course instruction, geriatric clinic rotations, and increased emphasis on geriatric topics in post-graduate continuing education courses.
4. Plan and start programs aimed at exposing health care professionals to healthy, active community-dwelling elders. Since severe vision loss is more frequent among older persons, we need to expand professional education with instructional emphasis on low vision rehabilitation in the health care and social service fields. As they become better informed, these professionals will become more effective referral sources for elders experiencing vision loss. Public and private sector must develop policies that offer employers incentives to make such reasonable accommodations as: (a) adjusted productivity goals to allow enough time for accuracy and quality; adjusted schedules allowing for part-time employment and breaks, as needed. (b) Sensory enhancement, including best optical correction for the employment task, low vision devices, and hearing aids when needed. (c) Referral to the appropriate rehabilitation services when sensory and/or physical disabilities develop. (d) Modification of technology (e.g. computer access) to enhance visibility, manipulation, and ergonomics; and (e) sensitivity by vocational rehabilitation agencies to issues related to older workers who hope to remain in the work force.
5. U. S. policy makers should look for opportunities to apply lessons learned in other highly industrialized nations that pro-actively incorporate older individuals into the workforce. For instance, an article in the June 25, 2005 issue of the Wall Street Journal chronicled how Japan has enacted a law that require companies by 2013 to raise their retirement age by 5 years or rehire their retiring workers. Adaptations for senior employees may include flex work shifts of 4 hours duration. Japan's government hopes that people working longer, with later retirement ages, will help save its increasingly burdensome pension system from, as the Wall Street Journal stated, "going bust."

Social Engagement

Barriers:

- 1 Older individuals, especially those with vision impairment, often have great difficulty safely crossing intersections, especially busy ones, because they may have difficulty seeing the traffic light as well as the **WALK** and **DON'T WALK** signs.
- 2 While driving safely is a key concern for everyone, changes in the aging eye make it especially relevant for older adults.
- 3 Society is demanding the use of the computer: To access information; to communicate; and to continue lifelong education, especially with online courses. Aging and vision loss, however, often pose serious obstacles in the challenge of accessing the computer.
- 4 Traveling independently is often linked with issues of quality of life. Independent travel is especially challenging and daunting in the presence of vision loss.
- 5 Overall, the barriers that stands in the way of older individuals pursuing healthy social interactions range from their lack of understanding about eye disease prevention to lack of funding to provide prevention-oriented eye health education, including mobility

problems that lead to social isolation or accidental falls. Falls among the elderly are a major medical and social concern.

Solutions:

1. **Priority #1:** Reexamine the role of the public sector to make policies that:
 - Help make affordable eye care available and accessible
 - Provide coverage for eye care services currently not covered under Medicare. Medicare should cover those preventive health vision services including refraction that are not currently covered.
 - Provide for more eye related research funding aimed at learning more about the role that poor vision plays in falls and about intervention techniques that will prevent falls and help cut the medical costs associated with the treatment and rehabilitation of resulting disabilities.
 - Require that all patients living in nursing home and other long-term-care facilities receive an annual eye examination at the facility.
 - Provide funding for the creation of educational tools for older adults that are culturally and ethnically sensitive.
2. Seek funding from the local Department of Transportation as well as the Business Improvement Districts to help underwrite the costs (e.g. such as New York City did in collaboration with the Lighthouse International) of developing a pilot project on installing Audible Pedestrian Signals (APS) at key street crossings in major cities in the United States.
3. Team up with automobile manufacturers, pharmaceutical manufacturers, and the optical industry to help underwrite the cost of mounting a nationwide educational campaign for keeping older drivers safely on the road by emphasizing:
 - The importance of regular eye examinations
 - The deleterious effects of some medications on driving
 - The problems of sudden changes in light level and the effects of glare when driving
 - The effects of eye conditions, especially cataracts, on driving safely
 - Insuring the use of lenses, filters, as well as specialized lenses (where applicable) to maximize safety when driving
 - The possible safety factor, as well as cost savings, in accessing public and alternative transportation.
4. Partner with computer and software manufacturers to underwrite the cost of developing and organizing a volunteer and community network of computer savvy high school and college students, as well as retirees, to teach:
 - The basics of computers, with emphasis on the built-in accessibility features (e.g. hi contrast and speech output)
 - The use of specialized software when vision loss is present (e.g. navigating the Web by voice and magnification software).
5. Offer computer programs for seniors at:
 - Low vision rehabilitation agencies
 - Low vision services in Optometry Universities and Colleges
 - Senior and community centers
6. Collaborate with seniors organizations, such as AARP and the Seniors Coalition to help

educate the public as well as: insure access and coverage to eye care for all older individuals, especially those with vision impairment; and support reimbursement for low vision aids and devices.

7. Leverage public and private resources and public/private partnerships to educate young and old alike about eye disease/injury prevention.
8. Encourage and motivate older adults to seek timely eye care, in keeping with the recommendations of their eye care professional and to avoid vision loss.
9. Encourage older adults to keep moving, to stay physically active and technology-savvy for fun, leisure and personal development.
10. Teach older Americans safe driving skills to maintain independence and personal and public safety
11. Educate older adults about the inherent value of developing a “take charge,” “can-do” attitude about their strengths, health and well-being.
12. Educate health professionals about the aging process, about compassion and understanding about the need to educate their patients.